

Less commonly observed were palpitation, anxiety, restlessness, anorexia, sore throat, delirium, and coma. Sore throat and swollen neck glands were found in two instances, with "malignant" neutropenia.

Toxic Effects.—A very good review of the toxic effects of dinitrophenol upon function and tissue has been made by MacBryde and Taussig,⁷ who have added some experimental results of their own. Among their conclusions we find: "Dinitrophenol in small doses caused functional changes indicative of toxicity in liver, heart and muscles, in a large percentage of patients in whom no special idiosyncrasy was noted. It also produced a loss of dextrose tolerance." If one carefully scans the effects of dinitrophenol on carbohydrate and fat metabolism, one is led to ponder upon the probability of permanent disturbances in both function and tissue subsequent to withdrawal of the drug.

Reported Deaths.—Seven of the 290 cases, of which we have spoken, eventuated in death; of these patients five received amounts of the drug well within the recommended therapeutic dosage.

Finally, experiences with dinitrophenol should emphasize the fact that "there is no royal road to reduction." Jones⁸ has well stated that people grow fat because of an excess of intake over output. It would seem that diet should still remain the fundamental keystone in the management of the overweight and obese patient: it should be supplemented by medication only as the individual case may require it.

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THE GENERAL PRACTITIONER AND PROSTATIC SURGERY

During the past four years volumes have been written in medical journals, and much has been written and said among the lay persons regarding the electrical, or "new" operation for enlarged prostates. Much of this literature is conflicting, and much of it is misleading, particularly that circulated among the laity. The old maxim, "a little knowledge is dangerous," is exemplified more vividly by the patients who think that they know about their illness or methods of treatment and surgical procedures. It is, therefore, not unusual to have a patient come to a physician with a preconceived idea of his ailment and the treatment indicated. With the proper explanation, the average intelligent patient can be convinced of the fallacy of his opinion, and the physician is permitted to work unhampered.

Much worse than the erroneous opinions of the patient are the erroneous ideas of the physician himself on subjects of which he can of necessity

not be thoroughly informed. I refer here to the subject of the treatment of prostatic hypertrophy. The physician who does not do genito-urinary surgery is not expected to keep completely informed of the details of the developments in urologic work. As stated before, the medical literature on the subject of treatment of prostatic hypertrophy has been so voluminous and conflicting that a perusal of the same would leave one somewhat confused. It is only the person who actually does the work, and is familiar with the disadvantages as well as the advantages of the various procedures, who can properly evaluate what he reads.

Further, the present status of the treatment of prostatic hypertrophy is sufficiently flexible to allow for several acceptable and desirable surgical procedures. The particular procedure to be selected for the case under consideration is determined by several factors, namely, the patient's general condition, associated urologic pathology, type of prostatic enlargement and, even at times, the patient's social status and future requirements. In order to determine the above factors, one must necessarily do a complete urologic examination. It is, therefore, apparent that the general practitioner who originally sees the patient and makes the diagnosis of prostatic obstruction is not in a position to make final recommendations as to the procedure indicated in the particular case. When the patient is told that he has an enlarged prostate that will probably require surgery, he frequently asks if he can be treated by the "new electrical method." Many prostatic patients have heard of others who have been operated in that way and, therefore, assume that they are eligible to the same procedure in contradistinction to the "old cutting operation." The patients have an impression that this is a simple procedure, with no risk attached to it and complete cure in every case. This is true in a large percentage of cases, but is, unfortunately, not true in every case. The attending physician is prone to promise the patient this new operation and to refer him to the urologist with that in mind. When the urologist completes his examination and tells the patient that he finds the resection to be undesirable, it is then very difficult to convince the patient of the need of the "cutting operation."

It would seem permissible, therefore, to make a plea to the referring physicians to leave the matter of choice of procedure to the urologist who will do the surgery. A large per cent of prostatic hypertrophies can be properly treated by resection, so one is justified, where necessary, in telling the patient that resection will probably be the indicated procedure. Many are of the belief that the most desirable method of handling this situation is to explain to the patient that he requires a complete urologic examination in order to determine the particular type of enlargement that he has, and to see if he has any associated pathology before recommending the type of surgery to be employed.

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⁷ MacBryde, C. M., and Taussig, B. L.: Functional Changes in Liver, Heart and Muscles, and Loss of Dextrose Tolerance Resulting from Dinitrophenol, J. A. M. A., 105: 13, 1935.

⁸ Jones, H. M.: The Basal Metabolic Rate in Simple and Pathological Obesity, J. Lab. and Clin. Med., 11:959, 1926.